A History of General Practice in Australia

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THE HISTORY OF GENERAL PRACTICE in Australia is of extreme interest, for it is essentially a study of the adaptation of British doctors and British practice to a wholly new and relatively isolated environment.[1] The terrain, vast and inhospitable; the climate, with its inverted seasons and its extremes; the occupations; the pattern of disease, all were strikingly different. Also different was the whole structure of society – physically, for example, in terms of the bias in its age constitution (toward younger and healthier age groups), and "psychologically", in its social, moral, political and educational backgrounds and standars.

Of course, the doctors who came to Australia were not a random sample of British practitioners, and perhaps it is as well that this was so. Precisely who came and why deserves deliberate study, for which adequate records and information probably exist. A few came as convicts, some came as surgeons to convict or emigrant ships (in the latter case, sometimes finding themselves stranded because they had failed to obtain guarantee of a return passage), and some came of official appointments in the administration or services. Many came as emigrants, free or assisted, seeking land, gold, adventure or more profitable employment than was available, for example, in Scotland over much of the 19th century. A great number came for the cure of their consumption. Many colonially distinguished practitioners might be cited, but perhaps the most impressive example was the leading London chest physician and inventor of the spirometer, Dr. John Hutchinson. He practiced quietly and obscurely in a mining town for several years, unfortunately without gaining any benefit from this much-vaunted, if somewhat protracted and expensive, therapeutic measure. Accompanying the regularly qualified medical practitioners, especially in the gold rush era, were a number with diplomas of dubious value and authenticity, a number of quacks with no diplomas at all, a leavening of sometime medical students and a significant group of homeopathic practitioners.

In most of the separate colonies then comprising Australia, medical registration was not too long delayed, and not too lax, to permit reasonable control over this situation, so that, with the stimulus of strong competition, satisfactory standards were, in the main, soon established and maintained. Indeed, it was probably the relative absence of the poorly-trained and the incompetent from the ranks of registered practitioners that enabled general practice in Australia to flourish rather than decline over a century or more, by comparison, for example, with the United States.

The medical practitioner rapidly assumed a social status in the community considerably above that accorded his colleagues in Britain. The reasons are not far to seek. Primarily, I believe, he earned great respect because of the obviously beneficial influence of a sound, conscientious surgeon on the morbidity and mortality of the convict ships. Indeed, the best report on the hygiene and medical conduct aboard convict transports was prepared by a former surgeon's mate in the Royal Navy, William Redfern, himself transported for a minor part played in the mutiny at the Nore. Redfern became an outstanding citizen of early Sydney, as well as the first doctor in full-time private general practice. The doctor's role was almost equally important in emigrant ships; travellers' tales record the reactions of passengers, many of whom had illnesses, or babies, en route, to both the best and worst of them, but the former, in the course of the long voyage, gained the respect and affection of Australia's first settlers.

A second reason lay in the fact that the doctor of average qualifications was better educated than many of his associates, even among the prominent, influential and wealthy members of this strangely egalitarian society, in the structure of which accidents of birth played no part. The doctor was prominent in all sorts of community activities, whether related to science, the arts or politics. The tendency, if not necessity, for him to migrate to country areas, where he greatly outnumbered army officers, parsons and lawyers, almost automatically conferred upon him a senior position in local society.

Thirdly, the great Australian distances meant

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isolation, often accentuated by flood, drought or bush fires, so that it was not a matter of "Which doctor?" but only "*The* doctor". He and his whereabouts were known to all, and his habits and qualities the study of all – not that the wild colonial population was critical (rather it was tolerant of eccentricity to a degree today's conformist society would find unacceptable), but to have this knowledge was a form of insurance. It was vitally important that the doctor could ride a horse or drive a buggy anywhere in all weathers, that he could find his way in trackless, unsignposted country, and even that he could return to instant sobriety on the arrival of an urgent call. In fact, these features probably readily distinguished the "real" doctor from the quack. Those who doubt the significance of these imponderable and unprofessional factors will find their doubts dispelled in the pages of contemporary poetry and prose.

Finally, virtually throughout the 19th century there was little or no intraprofessional gradient, that is to say, almost all doctors were in general practice on a more or less equal footing. An inevitable result of emerging specialization is that, in the public eye, there are doctors and better doctors, with pedestals of different heights.

Isolation and Status

On their part, the doctors responded to the dual stimuli of isolation and elevated status by providing what was, overall, an outstanding and uniquely adapted service, characterized in particular by the development of competence in all relevant fields of medicine and surgery. That this generalization, to which there were inevitable exceptions, is no rash overstatement is borne out by a study of both lay and medical literature of the period. This independence became a characteristic, and indeed a tradition, of Australian general practice; "physician and surgeon" read the brass plate until very recent years, and the doctor might equally reasonably have added obstetrician, gynecologist and anesthetist. The development of a highly individualistic approach was not, of course, the prerogative of the medical profession; the twin spirits of independence and social equality warmed the blood of squatters and swagmen, miners and shop assistants, and influenced the development of the national character (or, as more than one observer has said, we like to believe they did). Of course, a greater breadth of competence was not the only way in which general practice coped with the special environmental problems; in due course, aerial medical services and the pedal wireless were original Australian contributions to outback medical practice.

Development of Self-Reliance

Although isolation and distance were important in the development of self-reliance in practice, there were other more subtle factors. Obstetrics, for example, was very much the perquisite of the general practitioner throughout the 19th century, simply because of the shortage of trained midwives.[2] The concept of the independent, broadly competent doctor was also fostered by the local medical schools, which in themselves were a remarkable manifestation of colonial independence and self-sufficiency. The first, with a course lasting five years instead of the standard four, was established in 1863 in Melbourne, 600 miles from the nearest large town to north and south, and thousands of miles away from one in any other direction, barely 25 years after the area was first settled. Before the end of the century there were two more – at Sydney and Adelaide. It is significant in this context that chairs in medicine and surgery were not established in Melbourne for almost 90 years after the first professor (of anatomy, physiology and pathology) delivered his inaugural lecture.

The nature of medical practice, whether in town or country, was very different from that in Britain. The relative youth and health of the population meant that degenerative diseases were uncommon, except for those attributable to alcohol and syphilis. The "scatter" of the population meant that some of the acute infectious diseases of childhood did not at first become endemic. Outbreaks of infectious disease were at times dramatic, often with an age distribution, clinical picture and mortality somewhat different from British experience. Malnutrition, diseases related to exposure and the physicial environment (such as sunstroke, insanity and rheumatism), were more common, while commonest of all were accidents and trauma. Typhoid fever and tuberculosis became frequent in the latter half of the 19th century as the individual settlements grew into townships. When the sheep population increased sufficiently, hydatid disease increased in prevalence, leading to a series of classical contributions from Australian doctors, but otherwise, except for the very few practitioners in the tropical areas, there was nothing "exotic" about Australian practice, however bizarre its characteristics. It is perhaps notable that new overseas methods were very quickly tried in the colonies.[3, 4]

Demanding and Unremunerative Practice

It is not surprising that medical practice, based on the disorders mentioned, and conducted in relatively undeveloped areas thinly populated with healthy young people, was both demanding and comparatively unremunerative. Excellent fictional accounts, based on first-hand knowledge, are provided by E. Wardley's *Confessions of Wavering Worthy; An Ethical and Autobiographical Essay* (1864) and Henry Handel Richardson's classic, *The Fortunes of Richard Mahony* (originally published in three parts between 1917 and 1929, but relating to the period of the author's father). Many doctors had to find ways of supplementing their professional earnings; a surprising number, to the lasting benefit of the country, turned to viticulture. Dr. A. C. Kelly, for example, produced one of the earliest and most authoritative textbooks on *The Vine in Australia* (1861).

Competition was keen, as medical migrants had been numerous, especially in the cities. "Differences and dissensions seem lamentably common", Sir William Osler observed of the antipodean doctors.[5] The rivalry, at times accentuated by factional feuds related to such matters as club practice and homeopathy, led to professional conduct which would not readily be condoned today, and many disputes were carried on publicly in the newspapers or the law courts. Indeed, when one ponders over some of these – as, for example, a bitter newspaper argument over the diagnosis of measles, admittedly making its first appearance in the colony – one wonders that the public respect for the faculty was maintained, as it undoubtedly was.

By the turn of the century there were many signs of

change. The population had increased, and its age and sex constitution approached the European norm. As a result, and in part as a function of the development and stabilization of centers of settlement, the pattern of disease encountered altered. Former sporadic diseases, especially those of childhood, became endemic, although still of course with epidemic fluctuations. The increasing proportion of older subjects began to contribute more to overall morbidity rates, a point well illustrated by the shifting peak of tuberculosis morbidity from youth to middle age. "Sanitary reform" was having its effect, especially in rural towns. Public health legislation had developed to a considerable degree, and indeed some doctors began to express misgivings that a health department in the new Commonwealth of Australia might intensify the activities of health administrators. However, friendly society practice, at contract rates, in fact made more immediate inroads upon conventional private practice. The need for health education of the masses was accepted as a challenge, with the gradual development, on various bases and for various purposes, of advisory clinics. But the most significant change, certainly with the hindsight of three quarters of a century, was the emergence of specialists in many fields. Leaving aside the general practitioners with an interest and special competence in such fields as obstetrics and anesthesia, there were first the ophthalmologist, then the consultant surgeon and, a little slower to evolve, the physician; for a transitional period, a few consultants held honorary appointments as surgeon to one hospital and physician to another. This intra-professional hierachy inevitably pushed general practice towards the lower end of the professional scale, not necessarily in the view of other doctors, but certainly in the view of the general public. There is evidence (for example, the significant discussion on medical ethics at the Australasian Medical Congress in 1905) that, perhaps because of the previous absence of consultants, there was some lack of the niceties of the painstakingly evolved British pattern of professional etiquette, for example, in regard to the referral and acceptance of patients and to faulty communication and collaboration between consultant and general practitioner. No such generalization can be wholly true, of course, and it probably applied more to some cities and some specialties than to others.

There was a long period when specialist practice could be achieved not only by specifically oriented postgraduate training but also by the gradual acquisition in general practice, of special experience and expertise in a particular area. With the passage of time, and usually by a gradual process, the doctor could migrate to the local "Harley Street", as my father and many of his colleagues did. Inevitably the pattern of their practices differed from those of the more conventional specialist, who relied primarily upon the medical contracts of his hospital and teaching appointments. On the surgical side, the doubtful practice of "fee-splitting" between specialist and general practitioner grew up as a controversial issue. These matters were all of more immediate importance in the few major cities; specialization in rural centers was slow to evolve until the second half of the present century. Coincident with these changes in the profession proper, quackery in all its forms flourished as never before; the reason, I suspect, lay in the relatively impecunious state of the working classes, so that professional attention was expensive.

The genesis of today's problems is to be found in this period. It is a mistake to look for "causes" in the period after World War Two; one finds only the aggravating circumstances which threw these problems into relief against a background of medical practice which was not quite succeeding in adapting itself to a rapidly changing social framework and to an accelerated development of scientific medicine. These things had happened before, but more gradually; they are precisely analogous changes to those outlined briefly in the preceding paragraph.

As an illustration, it is customary, especially among politicians, to point to the spiralling cost of adequate medical care as central to the problem of providing for modern society's health and ills. In fact, this difficulty has been with us in varying forms and degrees for centuries. All organized societies throughout history have had to evolve methods, varying in efficiency and efficacy, for coping with sickness, the limits being set, as today, by what society wants and what it is prepared to pay. Appreciation of this, and acceptance of society's present demand that ill-health should not engender financial hardship and its unhealthy sequelae, allows the question of finance to be seen in proper historical perspective as one of methodology and not of principle. A natural corollary is that society, and not the medical profession, will determine this question. These professionally heretical notions, for which I plead the support of more profound historians such as Sigerist[6] and Shryock,[7] lead to the suggestion that both the more radical and the more conservative medical politicians might be wiser to compromise over an issue which cannot be won and might well be lost at the cost of irreparable rifts within the profession. *It is general practice itself which has most at stake.*

Emotional Connotation of "Nationalization"

This economic illustration was pursued a little further than may have seemed necessary to introduce a rash, but I hope thought-provoking, summary judgment on the early attempts to adapt medical practice to the new environment of the post-war period. Presuming again to discard the scarlet robes of the practicing physician for the sombre mantle of the historian, I suggest that our successors will look back at this era in puzzlement at the semantic confusion which clouded the material issues. A few words, such as "nationalization", acquired such a remarkable emotional content in the minds of politicians, doctors and the public, that detached examination and investigation of methods were almost overlooked. "Pigs", observed Stuart Chase, "are rightly named, since they are such dirty animals". In this atmosphere, the National Health Service was born and reared.[9] I am far too timid to attempt to evaluate it historically at this short distance in time. However, it is not necessary to decide whether it is good, bad or indifferent to accept that it has significantly influenced general practice and the provision of medical care to the community, and also that it may well have had a direct or indirect influence, perhaps not all to the good, on the public's attitude to the medical profession and to general practice. It is also unnecessary to decide on its merits or demerits before concluding that it will be altered,

perhaps radically so. One may perhaps find encouragement in the gradual changes which are occurring in the British system towards the evolution of more satisfactory conditions of general practice, notably in the assistance being given to the formation of "health centers". Such outside (or inside) assistance, meaning, in effect, finance, would greatly enhance the prospects of implementing newer concepts in general practice. The problem is most evident in the need to extend rural practice and make it more attractive, for which some plans exist – plans which are not sufficiently imaginative to form the basis of a solution to the total problem.

Practice Has Adapted Itself

Apart from such legislatively induced adaptation, general practice in Australia has adapted itself mainly in what might be termed a logistical sense to the altered social environment. There has been development of group practices (with their good and bad features), "lock-up" practices (for which there must be a demand, or else they would not survive), mobile radio-controlled services for out-of-hours or emergency calls, and accident flying squads; in some cases clinical or prescription records have been computerized, and for some continuing education has been maintained by means of special radio, or occasionally, television programs or tape recordings. A number of general practitioners are trying to modify their practices, perhaps most commonly by applying epidemiological methods, alone or in collaboration, to the study of common diseases, such as road accidents, to the evaluation of chronic disability in the community, and to the early detection of disease. The Royal Australian College of General Practitioners has done much to encourage research in and into general practice in recent years.

In spite of these partial adaptative measures, there remains a sense of frustration, born of a real or imagined decline in status and in professional independence, which is more strongly developed in Australia than in many other countries. Among the factors widely regarded as relevant are the growth of specialization, the increasing proportion of full-time medical officers in expanding health services, hospitals and industry, and current Australian policies in such matters as differentials in remuneration, especially for specialist services. In addition, patients are better educated, more informed on medical matters and more critical, quicker to seek specialist attention but, just as was pointed out in 1905, remarkably ignorant of the proper role of specialist or consultant particularly in relation to the general practitioner. I have heard it said by general practitioners that specialists also lack understanding of these points, just as I have heard the reverse; there is evidently some need for improved communication, again just as there was in 1905.

Restoration of Satisfying General Practice

The historian, then, may well see the solution to modern problems in a restoration of those conditions which served to make general practice satisfying (even if therapeutically less potent) in the 19th century. The valued tradition of independence, however the financial questions are resolved, must be encouraged by the development of definitive concepts of a new or enlarged role for the general practitioner, towards which his education must be more effectively oriented than it is in Australia at present. The opportunity for acquiring special skills and competence must be restored, whether in the traditional specialties or newer fields, such as sociology, epidemiology or "practical" psychiatry. As the profession can never again be as homogeneous as it was for an extended period in Australia, and as specialized investigation can only increase, the development of effective communication between all groups becomes perhaps of paramount importance. This is especially important, both for patients and the profession, between general practitioners and specialists or consultants; should any barrier arise, we shall regret it, as Sir William Allbutt[10] lamented the arbitrarily and artificially induced schism between medicine and surgery in medieval times, and for the same reasons. Finally, if there is some subtle "block" developing between profession and public, as I have an uneasy feeling there is, it must be comprehended and combatted. It was an economic block which encouraged quackery around 1900, and an economic and communication block which allowed the apothecaries to be interposed between the public and the duly qualified physicians in London over a century ago. Today, the pressure for registration of osteopaths and chiropractors and suggestions for trained "health visitors" imply the presence of another block, scarcely likely to be economic, and most likely related to attitudes, which might be reversible if we took the trouble to find out what they are.

Public Attitude To Doctors

This leads to one final consideration which, in our professional ivory tower, we are in danger of overlooking or underestimating. This is the attitude, not of *a* patient to *his* doctor, but the attitude of patients, or public, to doctors, or the medical profession. The former has probably scarcely changed since the days of the first medicine man, but the latter, based on a delicate balance of love and hate, has changed significantly in the past century or so. This may be most readily illustrated (although there are other sources) by comparing modern newspaper editorials and letters to the editor with those of 1870. The balance is no longer somewhat in favor of the doctors. Those making the comparison will wonder whether we have yet gone far enough in re-evaluating the role of the doctor in the community, or considered seriously enough the proposition that the public needs education in what that role may be. The question is not merely what role *we* think the doctor should play, but what role does *society* expect him to play, and, as a corollary, can we help society to decide. For throughout history, as Sigerist and Shryock, among others, have shown, the role of the doctor, the manner of his practice and, ultimately, his remuneration, have been determined by society, not by the profession. Though much of our training, experience and practice suggest the reverse, we are in fact servants, not masters, an observation I owe originally to a Canadian physician whose paper I have been unable to trace. Poynter[11] has recently drawn attention to the minor shock which the medical profession received when, contrary to its expectations, many "middle class" patients opted for hospital treatment in the National Health Service rather than for continuing to patronize private practitioners. Why?

There is an admirable trend towards estimating the

future role of general practice by employing scientific epidemiological principles to assess community needs. I wonder if the more artful approach of assessing community attitudes to modern medicine might not prove at least as productive and rewarding in reshaping this role. Yet I am not aware of a single critical historical study of the changes in the public's attitudes to doctors and of the reasons for them. We may not like the answers, but nevertheless it would be a most appropriate study for general practitioners to sponsor.

References

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The Royal Australian College of General Practitioners

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THE ROYAL AUSTRALIAN College of General Practitioners had its origins as the New South Wales Faculty of the (U.K.) College of General Practitioners in October 1953 and this was followed by the formation of the Queensland Faculty in January 1954.

In 1955, an Australian Council of the (U.K.) College of General Practitioners was formed and elected William Arnold Conolly as chairman and Howard Morris Saxby as honorary secretary. There followed inauguration of the Western Australia Faculty in January 1956, Tasmania in May 1957, Victoria in November 1957, and finally South Australia in February 1958. In the meantime, the Australian Council had discussed the formation of an independent Australian College and with the concurrence and cooperation of the British College, the Australian College of General Practitioners was formed in February 1958 with the basic objects of "establishing and maintaining high standards of learning, skill and conduct in the general practice of medicine and surgery".

Dr. W. A. Conolly was unanimously elected first president and thereby became the first fellow of the College. In May 1961 a Grant of Arms was made by the College of Arms and in 1969 the Queen granted the prefix "Royal".

Prior to 1961, the College had occupied offices in Macquarie Street, Sydney, but then moved to its present address at 43 Lower Fort Street, a building leased from the Maritime Services Board of New South Wales, in the oldest residential area of Sydney. Our present building, formerly known as Bligh House, was built about 1833 as a residence for Robert Campbell, a member of the N.S.W. Legislature and son of one of the pioneer merchants of Sydney. He was one of those concerned with stopping the transportation of convicts to the colony. Robert Campbell built the first serviceable wharf in the young colony and was instrumental in breaking the monopoly on trade held by the military (the "Rum Corps"). The building is a good example of the Colonial-Georgian architecture of the 1830s, with two stories above ground and a large basement below street level.

At present the College headquarters is on the top floor with extensive harbor views, while the ground floor contains the Council Room, lounge, service facilities and the office of the New South Wales Faculty. The basement houses the library and the housekeeper. The College is currently trying to raise money to restore the back verandah area, which was added long after the main building was erected, and which is out of keeping with the general architecture. The Australian National Trust has designated 43 Lower Fort Street in Category "A" of its list of historic buildings in New South Wales and the College is anxious to maintain the building in its original form.

In keeping with its original credo of maintaining high